

<i>SERFF Tracking Number:</i>	<i>PRLF-125859759</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40653</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>2008 Application Forms Filing</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Principal Life Insurance Company	SERFF Tr Num: PRLF-125859759	State: ArkansasLH
Product Name: 2008 Application Forms Filing	SERFF Status: Closed	State Tr Num: 40653
TOI: H16G Group Health - Major Medical	Co Tr Num:	State Status: Approved-Closed
Sub-TOI: H16G.001C Any Size Group - Other	Co Status:	Reviewer(s): Rosalind Minor
Filing Type: Form	Authors: Donna Burns, Dorthy Mcgrean, Brenda Mcleran	Disposition Date: 10/27/2008
	Date Submitted: 10/23/2008	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 10/27/2008	
State Status Changed: 10/27/2008	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	
See Cover Letter	

Company and Contact

Filing Contact Information

Dorthy McGrean, State/Federal Compliance mcgrean.dorthy@principal.com

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Analyst

711 High St. (800) 986-3343 [Phone]
Des Moines, IA 50392-0002 (515) 246-2491[FAX]

Filing Company Information

Principal Life Insurance Company	CoCode: 61271	State of Domicile: Iowa
711 High Street	Group Code: 332	Company Type: Life & Health
Des Moines, IA 50392	Group Name:	State ID Number:
(800) 986-3343 ext. [Phone]	FEIN Number: 42-0127290	

SERFF Tracking Number: PRLF-125859759 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$120.00
Retaliatory? No
Fee Explanation: 6 forms x \$20 = \$120
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$120.00	10/23/2008	23423526

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/27/2008	10/27/2008

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Disposition

Disposition Date: 10/27/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Additional Supporting Documentation	Approved-Closed	Yes
Form	Employer Application for Group Insurance	Approved-Closed	Yes
Form	Employee Enrollment and Waiver Form (with health questions)	Approved-Closed	Yes
Form	Health Statement Form	Approved-Closed	Yes
Form	Health Statement Form for Self Administered Plans	Approved-Closed	Yes
Form	Medical Simplified Health Statement for Groups with 51+ Lives	Approved-Closed	Yes
Form	Employee Enrollment and Waiver Form (with health questions) Template	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GP 45697-6	Application/ Employer Application Enrollment for Group Insurance Form	Revised	Replaced Form #: GP 45697-5 Previous Filing #: USPH-6NUNXY265	0	GP 45697-6.pdf
Approved-Closed	GP 48656-5	Application/ Employee Enrollment and Waiver Form (with health questions)	Revised	Replaced Form #: GP 48656-4 Previous Filing #: USPH-6NUNXY206	0	GP 48656-5.pdf
Approved-Closed	GP 47795-3	Application/ Health Statement Enrollment Form	Revised	Replaced Form #: GP 47795-2 Previous Filing #: USPH-6NUNXY206	0	GP 47795-3.pdf
Approved-Closed	GP 47796-3	Application/ Health Statement Enrollment Form for Self Administered Plans	Revised	Replaced Form #: GP 47796-2 Previous Filing #: USPH-6NUNXY206	0	GP 47796-3.pdf
Approved-Closed	GP 56357	Application/Medical Simplified Enrollment Health Statement for Groups with 51+ Lives	Initial		0	GP 56357.pdf
Approved-Closed	GP 56390	Application/ Employee Enrollment and Waiver Form (with health questions) Template	Initial		0	GP 56390.pdf

Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employer Application
for Group Insurance - AR

To avoid processing delays, please make sure you answer all questions completely and accurately.

This form is for: new case amendment (only complete sections with changes) Account number _____

Requested effective date: _____ Advance premium received \$ _____

Employer Information

Legal name of company _____

DBA name (if applicable) _____

C-corporation S-corporation limited liability company partnership sole proprietorship
other _____

Physical street address _____ City _____ State _____ ZIP code _____

Billing/mailling address (P.O. box) _____ City _____ State _____ ZIP code _____

Group contact name _____ Telephone number _____ FAX number _____ E-mail address _____

Billing contact name (if different) _____ Nature of business or SIC code _____ Federal tax ID number _____ Date company established _____

Have you been insured by Principal Life Insurance Company previously? yes no

If yes, when and under what name? _____

Has the company been denied credit within the past two years, ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy? yes no If yes, attach an explanation.

Have you elected a Health Reimbursement Arrangement with Principal Life? yes no

Have you elected a Health Savings Account with Principal Life? yes no

Complete the following if this coverage replaces other group insurance. Provide a copy of a recent billing and contract.

Note: Include prior carrier information for past three years.

Name of Carrier	Coverage(s)	Effective Date	Termination Date or Date Due to Terminate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employers with Multiple Locations or Participating Units

Does your business have more than one physical location? yes no If yes, list with complete addresses: _____

Is Division Billing requested? yes no If yes, indicate on enrollment materials which division or unit for each employee.

Are multiple bills requested? yes no (billing limitations may apply)

Are employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) to be covered? yes no If yes, please list the affiliate or subsidiary below.

Participating unit is an entity that is an affiliate or subsidiary related to the employer through common control or ownership.

Unit name/address/federal tax ID	Nature of business	Relationship to company	include unit exclude unit	Number of employees
1. _____	_____	_____	include unit exclude unit	_____
2. _____	_____	_____	include unit exclude unit	_____

Request for Benefits**210**

Illustrated in proposal number _____ Version number _____

Dental/vision/medical: Do you want insurance for: employees employees and dependents

If different by coverage, list: _____

dental voluntary dental vision voluntary vision

basic term life, options: accidental death and dismemberment accelerated death benefits dependent life

voluntary term life, options: accidental death and dismemberment accelerated death benefits

short term disability voluntary short term disability long term disability voluntary long term disability

If voluntary elected, verify billing mode: monthly semi-monthly weekly bi-weekly

(some billing options may not be available)

If voluntary elected, please provide last payroll date prior to effective date _____

medical: PPO number(s)/name(s) _____

If benefits differ by job class, please specify _____

Waiting Period (the length of time new employees must be employed before becoming eligible for insurance)

_____ days or _____ months or none

Should all employees hired on or before the effective date be enrolled on the group's effective date? yes no

If waiting period is different by job class, please specify _____

What day will employees be eligible?	<p>day immediately following the final day of the waiting period or change. Termination of coverage will be on the last day employee worked or was part of an eligible class.</p> <p>first day of the insurance month coinciding with or next following the final day of the waiting period or change. Termination of coverage will be the last day of the insurance month in which the employee worked or was part of an eligible class.</p>
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Employer ContributionComplete this table listing the percentage of premium the **employer** pays.

	Vision	Short term disability (STD)*	Long term disability (LTD)*	Basic term life	Voluntary term life	Medical	Dental
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
Dependent	_____ %	N/A	N/A	_____ %	_____ %	_____ %	_____ %
Retired	N/A	N/A	N/A	_____ %	N/A	_____ %	_____ %
Other	_____						

Are you requesting to insure retirees? yes no If yes, list coverages: _____

If yes, current retirees future retirees other _____

Note: Medical requires 51+ enrolled lives for retired coverage. Medical, life and dental are subject to Underwriting approval, and vision and disability are not available for retirees.

Definition of Compensation (Salary-Based Benefits) – Definition of compensation for owners is automatically included in all life and disability policies. **210**

base wage (excludes bonus, commission, overtime, etc.)	W-2 (1 year average)
base wage (with bonus)	W-2 (2 year average)
base wage (with commission)	W-2 (3 year average)
base wage (with commission and bonus)	contract salary
if different by class (please specify) _____	

Employee Eligibility

standard - An employee must work at least 30 hours per week to be eligible for insurance.
 other (select between 20 and 40 hours): _____ (not offered to groups subject to small employer legislation)

Ineligible Employees

- An independent contractor/1099 (unless required by law)
- An employee who works less than the required number of hours per week, or is employed as a temporary or seasonal employee, is not eligible for insurance.
- Employees residing or working in Hawaii (for medical coverage)

How many employees are on your payroll?	How many employees are eligible (based on hours worked per week)?
_____	_____

Describe any excluded class of employees or location _____

Do you have employees or their dependents residing or working outside the United States and requesting coverage?

yes no If yes, please include a separate sheet including their name(s), dates of birth, salary and class of employee, where they are located and how long they will be located there for work.

Complete the following sections for coverages being requested.

Disability

If you are requesting short term disability coverage, are there employees working in any of the states listed below (policies offered in these states are supplemental coverage only; they are not intended to provide coverage as outlined by each state)? yes no

If yes, indicate the number of employees for each state in the box.

California	Hawaii	New Jersey	New York	Rhode Island
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Life/Disability

If requesting life or disability insurance, are there any employees not actively at work or dependents in a period of limited activity (if dependent life insurance is requested)? yes no If yes, please list employees and dependents not actively at work, reason not actively at work, their last day worked and expected return to work date.

Dental

If you are replacing dental insurance, did your prior dental coverage include benefits for orthodontia treatment? yes no

Did your prior coverage include a dental maximum accumulation (max rollover, max builder)? yes no

If yes, please provide a copy of the prior carrier report showing individual maximums with roll over amounts.

Do you offer medical coverage to your employees through another carrier (not including insurance coverage that is being replaced)? yes no If yes, number of covered employees? _____

Is any employee presently not performing his/her duties on a full time basis due to an illness or injury?

yes no If yes, explain: _____

Employer Group Size for Medical (this information is in reference to Medicare status)

Companies that are affiliated or file a combined tax return must be considered one employer. Count the employees of all affiliated companies and units when answering the following questions.

#1. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding year? yes no If yes, you must also answer question #2. If no, skip question #2.

#2. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the previous calendar year? yes no

If 20 or 100 employees is reached mid-year, as of what date did you have 20 or 100 employees for the number of weeks required in the definition above? _____

Medical/Dental/Vision

COBRA eligibility is defined as employers who employed 20 or more full and full-time equivalent or part-time employees on at least 50% of the working days in the prior calendar year. Do you meet the eligibility definition? yes no

If COBRA applies, please select desired billing option: group bill policyholder direct bill continuee (individual)

If you currently have anyone on COBRA, please submit enrollment form with qualifying event date noted and reason for COBRA.

All Coverages

Employer elects to be:

standard accounting (Principal Life generates a monthly premium statement listing coverage(s) and premium for each member.)

self accounting - not available for medical coverage and prior approval required (Employer submits a monthly billing report to Principal Life listing member, member volume, premium and number of covered members.)

ERISA plan number: _____ Coverage: _____

ERISA plan number: _____ Coverage: _____

If more, attach list with ERISA plan number and coverage.

Plan administrator: _____

Plan sponsor: _____

Agent for legal services: _____

Ending date of plan's fiscal year: _____

The Employee Retirement Income Security Act of 1974 (ERISA) requires that each employee benefit plan subject to the Act designate a "Named Fiduciary who shall have authority to control and manage the operation and administration of the plan."

If this plan is subject to ERISA and the Named Fiduciary is other than the employer, fill in the information below. Principal Life may not be designated as Named Fiduciary.

The "Named Fiduciary" shall be: _____

Designation as Named Fiduciary is accepted. (Required only if the "Named Fiduciary" is an individual.)

By _____

Title _____

It is understood that Principal Life shall not be responsible for any tax or legal aspects of the plan. The employer assumes responsibility for these matters. The employer acknowledges that they have counseled to the extent necessary with selected legal and tax advisors. The obligations of Principal Life shall be governed solely by the provisions of its contracts and policies. Principal Life shall not be required to look into any action taken by the named fiduciary or the employer and shall be fully protected in taking, permitting, or omitting any action on the basis of the employer's actions. Principal Life shall incur no liability or responsibility for carrying out actions as directed by the named fiduciary or the employer.

It is further understood that by signing this application, the employer is purchasing insurance and not making an investment. No reserves, undeclared or unpaid experience premium refunds, or interest with respect to claim payments, nor claim proceeds themselves shall be considered plan assets under ERISA.

- The employer has been informed of the eligibility requirements. The employer agrees that insurance applied for shall not become effective or remain effective unless the employer: a) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit organization within the meaning of the Internal Revenue Code; or is a government agency; and b) meets the participation and contribution requirements.
- The employer agrees that insurance applied for shall not become effective unless the application and any attached page(s) are received, accepted and approved by Principal Life. If this application is accepted, all group policies will be combined and treated as one policy for the purpose of determining any experience premium refund. The employer acknowledges and understands that if this application is approved, the group policy will determine all rights and benefits.
- The preexisting condition restrictions for medical and long term disability insurance have been explained to and understood by the employer. Actively at work and period of limited activity for life coverage have been explained to and understood by the employer.
- The employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If a policy is issued from this application and is accepted by the proposed policyholder, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force, the premium deposit will be refunded. Premium payment will be monthly unless otherwise indicated.
- Acceptance by the employer of any policy or policies issued with this application shall constitute approval of any corrections, additions, or changes specified in the space "For Principal Life Use Only" or as otherwise indicated on this application.
- Your agent or broker cannot change or waive any provision of this application or the policy or policies without the written approval of an officer of Principal Life in the home office.
- As a result of this sale and any subsequent renewal, your broker and marketing organization, if any, may receive commissions, administrative service fees, other compensation including non-cash compensation, and bonuses based on factors such as, volume of new sales, member and case counts, total premium volume, maintaining a certain percentage of business with Principal Life, selling a certain mix of products, and/or the profitability of the business. The cost of this compensation may be directly or indirectly reflected in the premium or fee for the product(s) you have applied for on this application form. This compensation is in addition to any compensation the broker may receive from you. [Contact us at [1-800-388-4793, Options 4, 2, 2] for further details on your case.] [We have placed a more detailed description of our compensation programs on [www.principal.com/group/compensation].]
- The person signing this form for the employer has legal authority to bind the employer for whom application is being made.
- The employer agrees to make timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy.
- The employer understands their rights and responsibilities if electing self accounting status.

NOTE: If Principal Life determines, due to requirements of law or because of our own underwriting criteria, to issue our group insurance through a multiple-employer group insurance trust, the employer hereby subscribes to and agrees to the terms of that trust.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy.

Employer (company name)

Signed by (must be an officer)	Officer's title	Date signed
Licensed resident agent(s) (individual/firm)	Agent's license number	Date signed
Signature of soliciting agent(s) (If more than one, all must sign.)		Date signed

For Principal Life Use Only

Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - AR

Company name	Division level	Account number/unit number
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Employee Information

Your name (last, first, middle initial)				Social security number	
Mailing address (street)			Birth date		
			male female		
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child?		
			yes no		
Date employed full-time	Hours worked per week	Job occupation/class	Location		
Salary amount		Salary mode			
		yearly weekly hourly monthly bi-weekly			
What is your payroll mode?			Employer ZIP	Employer county	
monthly semi-monthly weekly bi-weekly					

Benefit Options (You can only elect those coverages offered by your employer.)

Coverage	Employee		Spouse		Children	
Medical	elect	decline	elect	decline	elect	decline
	Medical options: _____ (e.g., deductibles, PPO, etc.)					
Dental	elect	decline	elect	decline	elect	decline
	Dental options: _____ (e.g., deductibles, PPO, etc.)					
	In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself or your dependents) with a prior carrier? yes no					
Vision	elect	decline	elect	decline	elect	decline
Group term life	elect	decline	elect	decline	elect	decline
Voluntary term life (VTL)	elect	decline	elect	decline	elect	decline
	\$ _____ or _____ X annual salary		\$ _____		\$ _____	
	VTL only	VTL with AD&D	VTL only	VTL with AD&D		
Supplemental term life	elect	decline				
	\$ _____ or _____ X annual salary					
Short term disability (STD)	elect	decline	If STD Buy-up option is available, check one:		elect	decline
Long term disability (LTD)	elect	decline	If LTD Buy-up option is available, check one:		elect	decline
Important! If declining any coverage for yourself or any dependent, give reason. Covered under:						
spouse's group coverage		individual insurance		other coverage offered by employer		
other _____						

Nicotine Products

Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?
yes no

Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?
yes no

Important – Complete Page 1, Page 2, Page 3, Page 4, and Page 5.

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: If you are covered by both group term life and voluntary term life coverage and only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children.)

Spouse's name	Birth date	male	Social security number
		female	
Name(s) of child(ren)	Birth date		Social security number
		male	foster child*
		female	disabled or
			handicapped
			child**
		male	foster child*
		female	disabled or
			handicapped
			child**
		male	foster child*
		female	disabled or
			handicapped
			child**

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? yes no

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? yes no

Health Information for All Coverages Being Applied for (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. yes no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date _____) any complications _____ C-Section date _____ Multiple births? yes no)

2. yes no In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

☐cancer ☐alcohol☐/drug use ☐arthritis☐/bone☐/joint☐/muscle ☐skin☐/eye☐/ear☐/nose☐/throat
☐tumor ☐high cholesterol ☐allergy☐/asthma☐/respiratory ☐kidney☐/bladder☐/urinary
☐infertility ☐heart☐/circulatory ☐digestive☐/intestinal☐/eating ☐stroke☐/neurological☐/nervous system
☐liver☐/hepatitis ☐mental☐/nervous high blood pressure [– last reading and date ____ / ____]
☐diabetes – last HbA1c reading and date ____ / ____ ☐organ or other transplants
☐Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder
☐other – including other meds _____
☐tobacco use (which applicant: _____)

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		

Names of all medications

Names and addresses of doctors, hospitals or other providers

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life. If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions. I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Principal Life.

Instructions

- Employer – copy of Pages 1, 2, 3, and 5
- Employee – copy of Pages 1, 2, 3, 4, and 5

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Federal Regulations require an employee to receive the following notices for medical coverage offered in the state of Arkansas.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- completion of the maximum continuation period

Special Enrollment Rights (continued)

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete the Health Information section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Please keep these notices for your records.

Account number

Instructions for completing this form

1. The Employee Information section should always be completed with the information about the employee (do not include dependent or spouse information here).
2. The employee must ALWAYS sign the last page of this form.
3. When VTL is being requested for a spouse in addition to the employee, please follow the steps below:
 - a. If a health statement is needed for each person, a separate page 2 must be completed for the employee and the spouse.
 - b. The employee height/weight should be completed on page 2 for the employee and the spouse height/weight should be completed on page 2 for the spouse.
 - c. A spouse signature must be included on page 3 of the form.

Employee Information: After completed make a copy of Page 1, Page 2 and Page 3 for your records.

Your name (last, first, middle initial)		Home phone number	Social security number
Home address (street)			
City		State	ZIP code
Date of birth	Company name		

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete this Health Statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. yes no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date _____) any complications _____ C-Section date _____ Multiple births? yes no)

2. yes no In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

[cancer] [alcohol][drug use] [arthritis][bone][joint][muscle] [skin][eye][ear][nose][throat]
 [tumor] [high cholesterol] [allergy][asthma][respiratory] [kidney][bladder][urinary]
 [infertility] [heart][circulatory] [digestive][intestinal][eating] [stroke][neurological][nervous system]
 [liver][hepatitis] [mental][nervous] high blood pressure [– last reading and date ____ / ____]
 [diabetes – last HbA1c reading and date ____ / ____] [organ or other transplants]
 [Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder]
 [other – including other meds _____]
 [tobacco use (which applicant: _____)]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		

Names of all medications

Names and addresses of doctors, hospitals or other providers

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents and employees performing business transactions, any such data.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee's signature	Date signed
Spouse's signature*	Date signed

*Spouse signature only required if Voluntary Term Life coverage is elected.



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Health Statement
for Self Administered Plans – AR

Account Number / Unit Number

Employer to Complete This Section: After completing make a copy of Page 1 for your records before you give the form to your employee.

Employer name

Direct all employer's correspondence regarding this statement to:

Name

Address (street)

City

State

ZIP code

Phone

Employee's name

Social security number

Date of hire

Annual salary

\$

Effective date as per contractual provisions

first of month following approval

date of approval

other

open enrollment – effective date

This statement is: (place a "(√)" in each box that applies)

for employee

add new coverages

increase in current coverages

for dependent(s)

timely (made within eligibility period for employees).

over non medical maximum

Why is Health Statement being submitted?

late

Please check the coverages (**and indicate the new amount or increase in amount**) being applied for at this time. See your benefit plan/contract for proof of good health rules that apply to your plan.

	Current Benefit Amount	Total Requested Benefit Amount	
basic life	\$	\$	
supplemental life	\$	\$	
dependent life	\$	\$	
voluntary term life (employee)	\$	\$	
voluntary term life (spouse)	\$	\$	
voluntary term life (child)	\$	\$	
short term disability (benefit)	\$	\$	
long term disability (benefit)	\$	\$	core to buy up
disability qualification period	1 month	3 months	6 months
	other		

Employee to Complete This Section**120-0**

Your name (last, first, middle initial)				Home phone number	
Home address (street)					
City		State		ZIP code	
Date of birth		Are you married? male female yes no		Date of marriage	
Name of spouse		Spouse's social security number		Spouse's date of birth	

This statement is for:

myself

my spouse

my children

Name of each dependent child applying for coverage (last, first, middle initial)	Social security number	Sex	Date of birth	Full- time student	Foster/ step child*	Disabled or handicapped* child
1.						
2.						
3.						
4.						

Are additional children listed on separate page? yes Please sign and date all pages.

* Foster and stepchildren, eligibility is determined by employer. For disabled, handicapped children, complete the appropriate form.

Health Information for All Coverages Being Applied for

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. yes no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date _____) any complications _____ C-Section date _____ Multiple births? yes no)

2. yes no In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

☐cancer ☐alcohol[/drug use] ☐arthritis[/bone[/joint[/muscle] ☐skin[/eye[/ear[/nose[/throat]
☐tumor ☐high cholesterol ☐allergy[/asthma[/respiratory] ☐kidney[/bladder[/urinary]
☐infertility ☐heart[/circulatory] ☐digestive[/intestinal[/eating] ☐stroke[/neurological[/nervous system]
☐liver[/hepatitis] ☐mental[/nervous] high blood pressure [– last reading and date ____ / ____]
☐diabetes – last HbA1c reading and date ____ / ____] ☐organ or other transplants
☐Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder
☐other – including other meds _____]
☐tobacco use (which applicant: _____)]

Provide details for all "yes" answers. If more space is needed, attach a separate page giving full details. Sign and date all pages.

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment
-----------------------------------	-------------------

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment
-----------------------------------	-------------------

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment
-----------------------------------	-------------------

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life Insurance Company is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.

- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents and employees performing business transactions, any such data.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee's signature	Date signed
Spouse's signature*	Date signed

*Spouse signature only required if Voluntary Term Life coverage is elected.

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete this Health Statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Instructions for Employee

After this form is completed and signed, send original to Principal Life Insurance Company, Des Moines, IA 50392-0002, and make a copy for your records.

Account number

Employee Information: After completed make a copy of Page 1 and Page 2 for your records.

Your name (last, first, middle initial)		Home phone number	Social security number
Home address (street)			
City	State	ZIP code	
Date of birth	Company name		

Health Information

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. yes no In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- ☐ [cancer] ☐ [alcohol]/[drug use] ☐ [arthritis]/[bone]/[joint]/[muscle] ☐ [skin]/[eye]/[ear]/[nose]/[throat]
☐ [tumor] ☐ [high cholesterol] ☐ [allergy]/[asthma]/[respiratory] ☐ [kidney]/[bladder]/[urinary]
☐ [infertility] ☐ [heart]/[circulatory] ☐ [digestive]/[intestinal]/[eating] ☐ [stroke]/[neurological]/[nervous system]
☐ [liver]/[hepatitis] ☐ [mental]/[nervous] high blood pressure [– last reading and date ____ / ____]
☐ [diabetes – last HbA1c reading and date ____ / ____] ☐ [organ or other transplants]
☐ [Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder]
☐ [Any current pregnancy? (due date: ____)] ☐ [other – including other meds]
☐ [Any pending or scheduled surgery, any surgery or incurred medical/pharmacy claims in excess of \$5,000 (before insurance payment)?]
☐ [tobacco use (which applicant: ____)]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		
Names and addresses of doctors, hospitals or other providers		

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of my request for coverage under the group policy. I agree Principal Life Insurance Company is not liable for anyone's claim which happens or begins before the effective date of coverage.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I understand all policy provisions for medical coverage will apply.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.
- A photocopy of this form shall be as valid as the original.

Employee's signature	Date signed

Customized Enrollment Form With Statement of Health

Template Filing Document

ARKANSAS GP 56390

Principal Life Insurance Company uses a word template to create customized enrollment forms which are tailored specifically for each group based on the coverages the group has elected. The template is loaded with each possible piece of an enrollment form and user criteria is identified. The template then uses menus to gather information needed to pull in applicable sections of the form.

The Customized Enrollment Form with Statement of Health also has the capability to merge an excel file containing employee information which then creates an individualized (personalized) enrollment form for each employee. If employee data is merged a cover sheet containing the employee's name and address will appear as the first page of the enrollment. This step is optional.

For the purposes of this template document, each step and section has been provided in the order that it will occur or appear on the form. An explanation of when each will be used is stated above the step or section. Shading is used to help you see where the information pulls from.

The template begins with a Main Screen where the user building the form must complete coverage information, benefits, and provisions elected by the employer. A Dual Option Screen appears to the user if they elect a dental dual option plan on the Main Screen. The Dual Option Screen allows the user to enter a description of each dental plan design and whether the employer is contributing towards the premium amount. This is used when an employer offers more than one dental plan to their employees.

Enrollment sections, along with a description of when they will be used, will follow. Fields in are populated with information entered on the Main Screen or Dual Option Screen. Fields in are populated using information from the optional Excel file or this information can be entered manually as an employee completes the form.

This section always pulls in

 Pulls from the Main Screen

 Pulls from the Excel census file

110



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

**Employee
Enrollment &
Waiver - AR**

Company name 	Division level 	Account number/unit number
------------------------------------------------------------------	--------------------------------------------------------------------	--------------------------------------------------------------------------------

Employee Information

Name 			Social security number 	
Mailing address (street) 			Birth date 	<input checked="" type="checkbox"/> male <input type="checkbox"/> female
(city) 	(state) 	(ZIP code) 	Do you have an eligible spouse or child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date employed full-time 	Hours worked per week 	Job occupation/class 	Employer ZIP/Location 	

This section pulls in if a non-medical coverage (Life, VTL, STD, LTD) is selected on the Main Screen.

 Pulls from the Main Screen

 Pulls from the Excel census file

Salary amount 	Salary mode <input checked="" type="checkbox"/> yearly <input checked="" type="checkbox"/> weekly <input checked="" type="checkbox"/> hourly <input checked="" type="checkbox"/> monthly <input checked="" type="checkbox"/> bi-weekly			
What is your payroll mode? <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly			Employer county 	

This section pulls in if 1 plan Medical coverage is selected on the Main Screen.

The Decline box pulls in if coverage is contributory which is selected on the Main Screen.

Medical

Employee: <input type="checkbox"/> Elect <input checked="" type="checkbox"/> Decline	Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Children: <input type="checkbox"/> Elect <input type="checkbox"/> Decline
-----------------------------------------------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------------

This section pulls in if 2 plan Medical coverage is selected on the Main Screen. This occurs if the employer offers more than one Medical plan choice to their employees.

The Decline boxes pull in if coverage is contributory, which is selected on the Main Screen.

Medical

Plan 1

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

Plan 2

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

This section pulls in if 3 plan Medical coverage is selected on the Main Screen. This occurs if the employer offers more than one Medical plan choice to their employees.

The Decline boxes pull in if coverage is contributory which is selected on the Main Screen.

Medical

Plan 1

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

Plan 2

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

Plan 3

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

This section pulls in if Dental coverage is selected on the Main Screen.

The Decline box pulls in if coverage is contributory which is elected on the Main Screen.

The Orthodontia statement pulls in if Ortho Coverage is selected on the Main Screen.

Dental

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No

This section pulls in if Dental coverage is selected on the Main Screen.
The Decline boxes pull in if coverage is contributory which is elected on the Main Screen.
The Employer Contribution amounts pull in, if applicable, from the Dual Option Screen.
The Design Description pulls in from the Dual Option Screen.
The Orthodontia statement pulls in if Ortho Coverage is selected on the Main Screen.

Dental

☐ Elect ☐ Decline Choose from one of the following plans.

Plan #1

Employer Contribution

Design description:

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Child:

☐ Elect

☐ Decline

Plan #2

Employer Contribution

Design description:

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Child:

☐ Elect

☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No

This section pulls in if Vision coverage is selected on the Main Screen.
The Decline box pulls in if coverage is contributory which is selected on the Main Screen.

Vision

Employee:

☐ Elect

☐ Decline

Spouse:

☐ Elect

☐ Decline

Children:

☐ Elect

☐ Decline

This section pulls in if STD coverage is selected on the Main Screen.
The Decline box pulls in if coverage is contributory which is selected on the Main Screen.
The Buy-up option pulls in if selected on the Main Screen.

Short Term Disability

Employee: ☐ Elect ☐ Decline

STD Buy-up option, check one: ☐ Elect ☐ Decline

This section pulls in if LTD coverage is selected on the Main Screen.
The Decline box pulls in if coverage is contributory which is selected on the Main Screen.
The Buy-up option pulls in if selected on the Main Screen.

Long Term Disability

Employee: ☐ Elect ☐ Decline

LTD Buy-up option, check one: ☐ Elect ☐ Decline

This section pulls in if Group Term Life coverage is selected on the Main Screen.
The Decline box pulls in if coverage is contributory which is selected on the Main Screen.

Group Term Life

Employee:

☐ Elect ☐ Decline

This section pulls in if Group Term Life with Dependent Life coverage is selected on the Main Screen.
The Decline boxes pull in if coverage is contributory which is selected on the Main Screen.

Group Term Life

Employee:

☐ Elect ☐ Decline

Dependent Life:

☐ Elect ☐ Decline

This section pulls in if Supplemental Term Life Increment coverage is selected on the Main Screen.

Supplemental Term Life

Employee: ☐ Elect ☐ Decline \$ _____

This section pulls in if Supplemental Term Life Salary coverage is selected on the Main Screen.

Supplemental Term Life

Employee: ☐ Elect ☐ Decline _____ x annual salary

This section pulls in if Voluntary Term Life Increments Smoker/Non Smoker coverage is selected on the Main Screen.

Voluntary Term Life

Employee: ☐ Elect ☐ Decline \$ _____

Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? ☐ Yes ☐ No

Spouse: ☐ Elect ☐ Decline \$ _____

Birth date

Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? ☐ Yes ☐ No

Children: ☐ Elect ☐ Decline \$ _____

This section pulls in if Voluntary Term Life Increments Smoker/Non Smoker Employee Only coverage is selected on the Main Screen.

Voluntary Term Life

Employee: ☐ Elect ☐ Decline \$ _____

Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? ☐ Yes ☐ No

This section pulls in if Voluntary Term Life Increments Unismoker coverage is selected on the Main Screen.

Voluntary Term Life

Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	
Spouse:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	Birth date
Children:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	

This section pulls in if Voluntary Term Life Increments Unismoker Employee Only coverage is selected on the Main Screen.

Voluntary Term Life

Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____
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This section pulls in if Voluntary Term Life Percent of Salary Smoker/Non Smoker coverage is selected on the Main Screen.

Voluntary Term Life

Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	_____ x annual salary	
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Spouse:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	Birth date
Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Children:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	

This section pulls in if Voluntary Term Life Percent of Salary Smoker/Non Smoker Employee Only coverage is selected on the Main Screen.

Voluntary Term Life

Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	_____ x annual salary	
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			

This section pulls in if Voluntary Term Life Percent of Salary Unismoker coverage is selected on the Main Screen.

Voluntary Term Life

Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	_____ x annual salary	
Spouse:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	Birth date
Children:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	

This section pulls in if Voluntary Term Life Percent of Salary Unismoker Employee Only coverage is selected on the Main Screen.

Voluntary Term Life

Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	_____ x annual salary
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This section always pulls in.

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

- ☐ spouse's group coverage ☐ individual insurance
☐ other _____ ☐ other coverage offered by my employer

This section pulls in if Group Term Life is selected on the Main Screen.

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number

Name	Percentage	Relationship
Address		Social security number

This section pulls in if Voluntary Term Life is selected on the Main Screen.
 The "same as" and "NOTE:" statements pull in if Group Term Life and Voluntary Term Life coverage is selected on the Main Screen.

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

This section pulls in if Dental, Voluntary Term Life, Medical, Vision, or Group Term Dependent Life coverage is selected on the Main Screen.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

This section pulls in if 51 lives or more is selected on the Main Screen.

The "Read the Notice of Information Practices prior to answering" statement pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life is selected on the Main Screen. NOTE: The medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis and this type of change would only be implemented for all groups using the form from a specific date forward.

Health Information Questions – Groups with 51+ lives (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. ☐ Yes ☐ No In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- | | | | |
|-------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> [cancer] | <input type="checkbox"/> [alcohol] [/drug use] | <input type="checkbox"/> [arthritis] [/bone] [/joint] [/muscle] | <input type="checkbox"/> [skin] [/eye] [/ear] [/nose] [/throat] |
| <input type="checkbox"/> [tumor] | <input type="checkbox"/> [liver] [/hepatitis] | <input type="checkbox"/> [allergy] [/asthma] [/respiratory] | <input type="checkbox"/> [kidney] [/bladder] [/urinary] |
| <input type="checkbox"/> [infertility] | <input type="checkbox"/> [heart] [/circulatory] | <input type="checkbox"/> [digestive] [/intestinal] [/eating] | <input type="checkbox"/> [stroke] [/neurological] [/nervous system] |
| <input type="checkbox"/> [high cholesterol] | <input type="checkbox"/> [mental] [/nervous] | <input type="checkbox"/> high blood pressure [– last reading and date ____ / ____] | |
| <input type="checkbox"/> [diabetes – last HbA1c reading and date ____ / ____] | | | <input type="checkbox"/> [organ or other transplants] |

- ☐ [acquired immune deficiency syndrome (AIDS)/infection with HIV (human immunodeficiency virus)/other immune disorder]
- ☐ [any current pregnancies (due date: _____)] ☐ [other – including other meds]
- ☐ [any pending or scheduled surgery, any surgery or incurred medical/pharmacy claims in excess of \$5,000 (before insurance payment)?]
- ☐ [tobacco use (which applicant: _____)]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

This section pulls in if less than 51 lives is selected on the Main Screen.

The "Read the Notice of Information Practices prior to answering" statement pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life is selected on the Main Screen.

NOTE: The medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis and this type of change would only be implemented for all groups using the form from a specific date forward.

Health Information Questions (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. ☐ Yes ☐ No Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date _____)

any complications _____ C-Section date _____ Multiple births? ☐ Yes ☐ No)

2. ☐ Yes ☐ No In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- ☐ [cancer]
 ☐ [alcohol] [/drug use]
 ☐ [arthritis] [/bone] [/joint] [/muscle]
 ☐ [skin] [/eye] [/ear] [/nose] [/throat]
- ☐ [tumor]
 ☐ [liver] [/hepatitis]
 ☐ [allergy] [/asthma] [/respiratory]
 ☐ [kidney] [/bladder] [/urinary]
- ☐ [infertility]
 ☐ [heart] [/circulatory]
 ☐ [digestive] [/intestinal] [/eating]
 ☐ [stroke] [/neurological] [/nervous system]
- ☐ [high cholesterol]
 ☐ [mental] [/nervous]
 ☐ high blood pressure [– last reading and date ____ / ____]
- ☐ [diabetes – last HbA1c reading and date ____ / ____]
 ☐ [organ or other transplants]
- ☐ [acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder]
- ☐ [other – including other meds]
 ☐ [tobacco use (which applicant: ____)]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		

Any current symptoms or problems	Doctor and hospital names and addresses
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Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		

Any current symptoms or problems	Doctor and hospital names and addresses
----------------------------------	-----------------------------------------

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		

Any current symptoms or problems	Doctor and hospital names and addresses
----------------------------------	-----------------------------------------

This section pulls in if ONLY Medical coverage is selected on the Main Screen. If a non-medical coverage (Life, VTL, STD, LTD, Dental, Vision) is elected then this section will pull in later in the form.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X _____ **Date Signed** _____

This section always pulls in.

The first yellow bullet only pulls in if Dental coverage is selected on the Main Screen.

The second yellow bullet only pulls in if Medical coverage is selected on the Main Screen.

The third yellow bullet only pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life.

The fourth yellow bullet only pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life.

The fifth yellow bullet only pulls in if Group Term Life or Voluntary Term Life.

The sixth yellow bullet only pulls in if Medical is selected on the Main Screen.

Principal®

**Financial
Group**

Mailing Address
Des Moines, IA 50392-0002

**Principal Life
Insurance Company**

**Employee
Enrollment &
Waiver - AR**

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions, or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself or my dependents will be sent to my home address. I also understand collection of social security numbers for myself or my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

A copy of this form will be as valid as the original.

This section pulls in here if a non-medical coverage (Life, VTL, STD, LTD, Dental, Vision) is selected on the Main Screen.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X _____ Date Signed _____

This section pulls in if a Medical coverage is selected on the Main Screen.



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - AR

Federal Regulations require an employee to receive the following notices for medical coverage offered.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- an incurred claim that would meet or exceed a lifetime limit on all benefits

- completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

This section pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life is selected on the Main Screen.

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete the Health Information section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

This section always pulls in.

Please keep these notices for your records.

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

SERFF Tracking Number: *PRLF-125859759*

State: *Arkansas*

Filing Company: *Principal Life Insurance Company*

State Tracking Number: *40653*

Company Tracking Number:

TOI: *H16G Group Health - Major Medical*

Sub-TOI: *H16G.001C Any Size Group - Other*

Product Name: *2008 Application Forms Filing*

Project Name/Number: */*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: PRLF-125859759 State: Arkansas
Filing Company: Principal Life Insurance Company State Tracking Number: 40653
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2008 Application Forms Filing
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 10/27/2008
Comments:
Attachment:
Readability Certification.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 10/27/2008
Bypass Reason: See Form Schedule for GP 45697-6 to be approved. This application replaced GP 45697-5 which was previously approved on 6-9-06.
Comments:

Satisfied -Name: Additional Supporting Documentation **Review Status:** Approved-Closed 10/27/2008
Comments:
Attachments:
Samples GP 56390 A, B and C.pdf
2008 Application Forms Cover Letter.pdf
2008 Application Forms Addendum.pdf

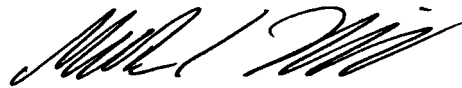
**STATE OF ARKANSAS
INSURANCE DEPARTMENT**

CERTIFICATION OF READABILITY

I, Mark L. Hill, an Officer of Principal Life Insurance Company hereby certify that the attached form(s) complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

GP 45697-6
GP 48656-5
GP 47795-3
GP 47796-3
GP 56357
GP 56390

PRINCIPAL LIFE INSURANCE COMPANY



Mark L. Hill, Director
Group Life and Health Compliance

October 23, 2008

Date

12/1999





Sample A - 1 plan Medical with 51+ lives

Mailing Address
Des Moines, IA 50392-0002

**Principal Life
Insurance Company**

**Employee
Enrollment &
Waiver - AR**

Company name	Division level	Account number/unit number
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Employee Information

Name			Social security number	
Mailing address (street)			Birth date	<input type="checkbox"/> male <input type="checkbox"/> female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date employed full-time	Hours worked per week	Job occupation/class	Employer ZIP/Location /	

Medical

Employee: ☐ Elect ☐ Decline Spouse: ☐ Elect ☐ Decline Children: ☐ Elect ☐ Decline

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's group coverage ☐ individual insurance
☐ other _____ ☐ other coverage offered by my employer

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Health Information Questions – Groups with 51+ lives

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ___ ft. ___ in. weight _____ lbs. Spouse's height ___ ft. ___ in. weight _____ lbs.

1. ☐ Yes ☐ No In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor,

had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- ☐ cancer ☐ alcohol/drug use ☐ arthritis/bone/joint/muscle ☐ skin/eye/ear/nose/throat
☐ tumor ☐ liver/hepatitis ☐ allergy/asthma/respiratory ☐ kidney/bladder/urinary
☐ infertility ☐ heart/circulatory ☐ digestive/intestinal/eating ☐ stroke/neurological/nervous system
☐ high cholesterol ☐ mental/nervous ☐ high blood pressure – last reading and date ____ / ____
☐ diabetes – last HbA1c reading and date ____ / ____ ☐ organ or other transplants
☐ acquired immune deficiency syndrome (AIDS)/infection with HIV (human immunodeficiency virus)/other immune disorder
☐ any current pregnancies (due date: _____) ☐ other – including other meds
☐ any pending or scheduled surgery, any surgery or incurred medical/pharmacy claims in excess of \$5,000 (before insurance payment)?
☐ tobacco use (which applicant: _____)

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment
-----------------------------------	-------------------

Names of all medications

Any current symptoms or problems	Doctor and hospital names and addresses
----------------------------------	-----------------------------------------

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment
-----------------------------------	-------------------

Names of all medications

Any current symptoms or problems	Doctor and hospital names and addresses
----------------------------------	-----------------------------------------

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment
-----------------------------------	-------------------

Names of all medications

Any current symptoms or problems	Doctor and hospital names and addresses
----------------------------------	-----------------------------------------

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X _____ **Date Signed** _____



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - AR

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment.
- If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions, or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself or my dependents will be sent to my home address. I also understand collection of social security numbers for myself or my dependents will be used by Principal Life only as allowed by law.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

A copy of this form will be as valid as the original.



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

**Employee
Enrollment &
Waiver - AR**

Federal Regulations require an employee to receive the following notices for medical coverage offered.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child

- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

Please keep these notices for your records.

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

Principal®**Financial
Group****Sample B - 2 plan Medical with < 51 lives, 1 plan Dental with Orthodontia,
STD with buy-up, and VTL Increments Smoker/nonsmoker**

110

Mailing Address
Des Moines, IA 50392-0002**Principal Life
Insurance Company****Employee
Enrollment &
Waiver - AR**

Company name

Division level

Account number/unit number

Employee Information

Name

Social security number

Mailing address (street)

Birth date

☐ male☐ female

(city)

(state)

(ZIP code)

Do you have an eligible spouse or child?

☐ Yes ☐ No

Date employed full-time

Hours worked per week

Job occupation/class

Employer ZIP/Location
/

Salary amount

Salary mode

☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly

What is your payroll mode?

☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly

Employer county

Medical

Employee:

☐ Elect☐ Decline

Spouse:

☐ Elect☐ Decline

Children:

☐ Elect☐ Decline**Dental**

Employee:

☐ Elect☐ Decline

Spouse:

☐ Elect☐ Decline

Children:

☐ Elect☐ DeclineIn the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No**Short Term Disability**Employee: ☐ Elect ☐ DeclineSTD Buy-up option, check one: ☐ Elect ☐ Decline

Voluntary Term LifeEmployee: ☐ Elect ☐ Decline

\$ _____

Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? ☐ Yes ☐ NoSpouse: ☐ Elect ☐ Decline

\$ _____

Birth date

Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? ☐ Yes ☐ NoChildren: ☐ Elect ☐ Decline

\$ _____

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:☐ spouse's group coverage☐ individual insurance☐ other _____☐ other coverage offered by my employer**Voluntary Term Life Beneficiary Designation** (Complete if covered for voluntary term life coverage)**All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.****Primary Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Health Information Questions (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ___ ft. ___ in. weight _____ lbs. Spouse's height ___ ft. ___ in. weight _____ lbs.

1. ☐ Yes ☐ No Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date _____) any complications _____ C-Section date _____ Multiple births? ☐ Yes ☐ No)

2. ☐ Yes ☐ No In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- ☐ cancer ☐ alcohol/drug use ☐ arthritis/bone/joint/muscle ☐ skin/eye/ear/nose/throat
☐ tumor ☐ liver/hepatitis ☐ allergy/asthma/respiratory ☐ kidney/bladder/urinary
☐ infertility ☐ heart/circulatory ☐ digestive/intestinal/eating ☐ stroke/neurological/nervous system
☐ high cholesterol ☐ mental/nervous ☐ high blood pressure – last reading and date _____ / _____
☐ diabetes – last HbA1c reading and date ____ / _____ ☐ organ or other transplants
☐ acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder
☐ other – including other meds ☐ tobacco use (which applicant: _____)

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems	Doctor and hospital names and addresses	
Name	Date diagnosed/treated	Length of illness or condition

Diagnosis of illness or condition		Type of treatment
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses
Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - AR

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions, or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself or my dependents will be sent to my home address. I also understand collection of social security numbers for myself or my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X _____ **Date Signed** _____



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

**Employee
Enrollment &
Waiver - AR**

Federal Regulations require an employee to receive the following notices for medical coverage offered.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete the Health Information section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Please keep these notices for your records.

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

Sample C - Employee data merged. 1 plan Medical with 51+ lives, Dental 2 plan with Orthodontia, Noncontributory Vision, Short Term Disability, Long Term Disability with Buy-up, Noncontributory Group Term Life, Voluntary Term Life Percent of Salary Unismoker

Jane Doe
111 1st Street
Des Moines, Iowa 50111



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - AR

Company name ABC Company	Division level	Account number/unit number H12345
-----------------------------	----------------	--------------------------------------

Employee Information

Name Jane Doe			Social security number	
Mailing address (street) 111 1 st Street			Birth date 10/15/1975	<input type="checkbox"/> male <input checked="" type="checkbox"/> female
(city) Des Moines	(state) Iowa	(ZIP code) 50111	Do you have an eligible spouse or child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date employed full-time 05/01/2004	Hours worked per week 40	Job occupation/class Sales Manager	Employer ZIP/Location 50222/Des Moines	
Salary amount 40,000	Salary mode <input checked="" type="checkbox"/> yearly <input type="checkbox"/> weekly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly			
What is your payroll mode? <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly			Employer county Polk	

Medical

Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Children: <input type="checkbox"/> Elect <input type="checkbox"/> Decline
------------------------------------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------------

Dental

☐ Elect ☐ Decline Choose from one of the following plans.

Plan #1 Your employer is contributing 50%

Design description: High Plan

Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Child: <input type="checkbox"/> Elect <input type="checkbox"/> Decline
------------------------------------------------------------------------------	----------------------------------------------------------------------------	---------------------------------------------------------------------------

Plan #2

Design description: Low Plan

Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Child: <input type="checkbox"/> Elect <input type="checkbox"/> Decline
------------------------------------------------------------------------------	----------------------------------------------------------------------------	---------------------------------------------------------------------------

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No

Vision

Employee: <input type="checkbox"/> Elect	Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Children: <input type="checkbox"/> Elect <input type="checkbox"/> Decline
---------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------------

Short Term Disability

Employee: ☐ Elect ☐ Decline

Long Term DisabilityEmployee: ☐ Elect ☐ DeclineLTD Buy-up option, check one: ☐ Elect ☐ Decline**Group Term Life**

Employee:

☐ Elect**Voluntary Term Life**Employee: ☐ Elect ☐ Decline

_____ x annual salary

Spouse: ☐ Elect ☐ Decline

\$ _____

Birth date

Children: ☐ Elect ☐ Decline

\$ _____

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:☐ spouse's group coverage☐ individual insurance☐ other _____☐ other coverage offered by my employer**Group Term Life Beneficiary Designation** (Complete if covered for group term life coverage.)**All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.****Primary Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Health Information Questions – Groups with 51+ lives (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight ____ lbs. Spouse's height ____ ft. ____ in. weight ____ lbs.

1. ☐ Yes ☐ No In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- ☐ cancer ☐ alcohol/drug use ☐ arthritis/bone/joint/muscle ☐ skin/eye/ear/nose/throat
- ☐ tumor ☐ liver/hepatitis ☐ allergy/asthma/respiratory ☐ kidney/bladder/urinary
- ☐ infertility ☐ heart/circulatory ☐ digestive/intestinal/eating ☐ stroke/neurological/nervous system
- ☐ high cholesterol ☐ mental/nervous ☐ high blood pressure – last reading and date ____ / ____
- ☐ diabetes – last HbA1c reading and date ____ / ____ ☐ organ or other transplants
- ☐ acquired immune deficiency syndrome (AIDS)/infection with HIV (human immunodeficiency virus)/other immune disorder
- ☐ any current pregnancies (due date: _____) ☐ other – including other meds
- ☐ any pending or scheduled surgery, any surgery or incurred medical/pharmacy claims in excess of \$5,000 (before insurance payment)?
- ☐ tobacco use (which applicant: _____)

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems	Doctor and hospital names and addresses	
Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems	Doctor and hospital names and addresses	



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - AR

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions, or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself or my dependents will be sent to my home address. I also understand collection of social security numbers for myself or my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X _____ **Date Signed** _____



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

**Employee
Enrollment &
Waiver - AR**

Federal Regulations require an employee to receive the following notices for medical coverage offered.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete the Health Information section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Please keep these notices for your records.

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer



**Principal Life
Insurance Company**

October 23, 2008

Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE Employer Application, Employee Enrollment Forms, and Health Statements for Group Insurance see Forms Schedule tab
Principal Life Insurance Company NAIC No. 61271-332
FEIN # 42-0127290

Enclosed please find copies of each form as shown under the Forms Schedule tab. The revisions to these forms are described on the Forms Addendum included with this filing under the Supporting Documentation tab. The Forms Addendum includes a description of each form as well as a list of the applicable group products the forms will be used with.

To keep current with changes taking place in the insurance industry, we are revising several of the forms that we use in our underwriting and administration processes. This includes having multiple versions of enrollment forms and health statements to use depending on what coverages a group policyholder purchases from us. As noted above, the enclosed Addendum provides an explanation of the changes on the enclosed forms as well as information on the new forms we are adding for use at this time.

Thank you for your consideration of this submission. All required certification forms are enclosed. The applicable filing fee has been sent via EFT.

If you have any questions on any of the enclosed materials, please feel free to contact me by fax, e-mail or at the toll-free number shown.

Sincerely,

A handwritten signature in black ink that reads "Dorothy McGrean". The script is cursive and fluid, with the first name "Dorothy" and last name "McGrean" clearly legible.

Dorothy McGrean
State/Federal Compliance Analyst
Group Life and Health Compliance
Principal Life Insurance Company
Des Moines, IA 50392-0002
Phone 1-800-986-3343 (Ext. 82835)
Fax 515-246-2491
<mailto:mcgrean.dorothy@principal.com>

ADDENDUM – ARKANSAS APPLICATION FORMS LIST REVISION DESCRIPTION

A list of Group products that will be using these forms is included at the end of this Addendum. Any exceptions to the product list are described in the specific form information included below.

1. Employer Application for Group Insurance (GP 45697-6) – This form is being revised to clarify questions that sometimes result in incorrect or missing information during the application/issue process. This form replaces the previously filed and approved Employer Application Forms as noted on the Forms Schedule tab for new business sold after the date of approval of this form. Here is a brief list of the items that were changed on this form:
 - Employer Information section – DBA name section added; billing and contact information revised/added; nature/effective date of business added; questions regarding Health Reimbursement Arrangements and Health Savings Accounts added
 - Employers with Participating Units section – added information about multiple locations and multiple billings
 - Request for Benefits section – reformatted to put coverage options in a different order; added information regarding billing options and job classes
 - Waiting Period/Effective Date Provisions section – revised waiting period options and to clarify how the effective dates apply
 - Employer Contribution section – revised to clarify which coverages provide retiree coverage
 - Definition of Compensation section – revised to include information about owners and to ask about differences by classes; removed information about salary changes for benefits based on salary
 - Employee Eligibility section – revised to clarify choices available to employers and to clarify ineligible employees; revised questions regarding number of employees and the number eligible for group benefits
 - Disability section – revised to clarify state disability plan requirements
 - Life/Disability section – revised dependent information to add period of limited activity wording for dependents; revised actively at work information
 - Dental section – added questions regarding prior dental plans
 - Medical section – revised question about the employer offering coverage through another carrier
 - Employer Group Size for Medical – this section is being added to gather information about groups who may be subject to Medicare secondary payor laws
 - Medical/Dental/Vision section – minor change to COBRA question (asking for reason persons are on COBRA)
 - All Coverages section – added information to clarify the accounting types
 - Agreement and Signatures section:
 - The first bullet item was revised to add reference to governmental agency.
 - Several bullet items regarding similar provisions have been combined.
 - A new bullet item for commission information has been added. This item includes two statements that are shown in brackets for the purpose of this filing – the brackets will not appear with these statements when the form is activated at the present time. One or both of these statements may be removed if Principal Life provides this information to employers in another manner at some point in the future. Use of these statements will not change on a group by group basis – the same version will be used for all employer groups in the state. The

ADDENDUM – ARKANSAS APPLICATION FORMS LIST REVISION DESCRIPTION

phone number and website used in these statements are also shown in brackets in case they need to be changed at some point in the future.

2. Employee Enrollment and Waiver Form (with health questions) (GP 48656-5) – This form combines an employee enrollment form and a health statement. This form replaces the previously filed and approved Employee Enrollment and Waiver form (with health questions) as noted on the Forms Schedule tab and will be used to enroll employees for new groups as well as existing groups after the date of approval of this form. Here is a brief list of the items that were changed on this form:
 - Nicotine Products section – these questions were revised to add information about additional tobacco products
 - Eligible Dependent section – a question has been added asking if the employee’s spouse is employed by the same employer
 - Health Information Questions section:
 - This section has been revised to show a new question format, which matches the format used on the health statements described later in this Addendum.
 - Additional medical conditions have been added or clarified. These medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis - this type of change would only be implemented for all groups using the form from a specific date forward. Note: The item for “tobacco use (which applicant: _____)” is not being implemented at this time.
 - Employee Signature section – the heading has been revised to show as Employee Agreement
3. Health Statement form (GP 47795-3) – This form is used by our standard accounting cases (which means we handle the enrollment process for the groups). It is used to review medical history when more detailed medical information is required and the combined enrollment/health statement form (described above in this Addendum) was not used. This form replaces the previously filed and approved Health Statement Form as noted on the Forms Schedule tab. Here is a brief list of the items that were changed on this form:
 - Instructions section – this was added to the beginning of the form to clarify how the form needs to be completed. It includes instructions regarding information needed when both an employee and a spouse are applying for amounts of voluntary life coverage that require a health statement.
 - Health Information section:
 - The health questions have been revised from a five question format to a two question format.
 - Additional conditions have been added or clarified. These medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis and this type of change would only be implemented for all groups using the

ADDENDUM – ARKANSAS APPLICATION FORMS LIST REVISION DESCRIPTION

form from a specific date forward. Note: The item for “tobacco use (which applicant: _____)” is not being implemented at this time.

- The section asking for more detailed information has been revised to have a separate line for the names of all medications.
4. Health Statement form for Self Administered Plans (GP 47796-3) – This form is used by our self accounting cases (which means the employer handles the enrollment process for the groups and reports billing information to us). It is used to review medical history for life and disability coverage when more detailed medical information is required and the combined enrollment/health statement form (described above in this Addendum) was not used. This form is not used for medical coverage issued under our GC 5000 et al Medical Expense Insurance series policy forms. This form replaces the previously filed and approved Health Statement Form for Self Administered Plans as noted on the Forms Schedule tab. Here is a brief list of the items that were changed on this form:
- Employer to Complete section – changes were made to the headings under the coverage election section to better indicate the total benefit amount being requested.
 - Health Information section:
 - The health questions have been revised from a five question format to a two question format.
 - Additional conditions have been added or clarified. These medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis - this type of change would only be implemented for all groups using the form from a specific date forward. Note: The item for “tobacco use (which applicant: _____)” is not being implemented at this time.
 - The section for more detailed information has been revised to have a separate line for the names of all medications.
5. Medical Simplified Health Statement for Groups with 51+ Lives (GP 56357) – This is a new form which is used only for policyholders with more than 51 employees who have elected medical coverage. It does not replace any Health Statement forms currently in use. It will be used only for our GC 5000 et al Medical Expense Insurance series policy forms. The medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis - this type of change would only be implemented for all groups using the form from a specific date forward. Note: The item for “tobacco use (which applicant: _____)” is not being implemented at this time.
6. Employee Enrollment and Waiver form template (with health questions) (GP 56390) – This is a new form is based on the enrollment form described in item 2 above, however, the content of this form varies based on the coverages elected by the policyholder, so the form is customized to match the specific coverages for each policyholder that elects to use the form. This enrollment form is produced by personal computer. If a specific policyholder elects just life and medical coverage, only these two coverages will appear on the form. The attached

ADDENDUM – ARKANSAS APPLICATION FORMS LIST REVISION DESCRIPTION

template indicates what text will be pulled into the actual form depending on the coverages elected by the policyholder. See the information shown in red font on the template – this text will not appear on the final enrollment form created for a specific policyholder.

The form includes two different health statement sections – one will be used for medical cases that have 51 or more employees and the other will be used for medical cases with less than 50 employees. These medical health statement sections contain the same questions that are in the health statements described earlier in this Addendum. The medical conditions in these sections are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis - this type of change would only be implemented for all groups using the form from a specific date forward. The final form (printed in black font) will be provided to the employees as a paper form for their review and signature. Note: The item for “tobacco use (which applicant: _____)” is not being implemented at this time.

This enrollment form template also includes the ability to download employee information from a spreadsheet provided by a policyholder to pre-fill some of the content on the form, such as the employee name, address, employment information, etc.

The template includes all coverages and options available for policyholders to elect for their employees. To help with your review of the template, we have included some examples of actual enrollment forms based on specific coverages so you can see what the final form will look like, depending on the options elected by a policyholder. The examples are marked as Samples GP 56390 A, B, and C, and are attached under the Supporting Documentation Tab.

ADDENDUM – ARKANSAS APPLICATION FORMS LIST REVISION DESCRIPTION

PRODUCT LIST

Except where noted earlier in this Addendum, the forms listed in this Addendum will be used with the following previously approved Group Insurance products:

Policy Form Numbers	Group Product Coverage
GC 100 et al	Group Term Life Insurance (existing business only)
GC 1000 et al	Group Voluntary Term Life Insurance (existing business only)
GC 6000 et al	Group Term Life Insurance
GC 6000 (VTL) et al	Group Voluntary Term Life Insurance
GC 300 et al	Group Long Term Disability Insurance (existing business only)
GC 3000 et al	Group Long Term Disability Insurance
GC 400 et al	Group Short Term Disability Insurance (existing business only)
GC 4000 et al	Group Short Term Disability Insurance
GC 700 et al	Group Dental Expense Insurance (Indemnity) (existing business only)
GC 700 (PPO) et al	Group Dental Expense Insurance (PPO) (existing business only)
GC 2000 et al	Group Voluntary Dental Expense Insurance (Indemnity) (existing business only)
GC 2000 (PPO) et al	Group Voluntary Dental Expense Insurance (PPO) (existing business only)]
GC 7000 et al	Group Dental Expense Insurance
GC 7100 et al	Group Dental Expense Insurance
GC 900 et al	Group Vision Expense Insurance
GC 5000 et al	Group Medical Expense Insurance